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ABSTRACT

This paper discusses attitudes that may come into play when a parent enters the treatment picture with a disturbed student. The attitudes of therapists toward parents, including sources of bias, and reasons for controlling it, are presented. The attitudes of parents toward their emotionally disturbed child, toward treatment, and toward therapists are discussed, along with examples of questions newly informed parents may have for the therapist. The student's attitudes toward the parent-therapist communications are discussed, focusing on issues of loyalty and the nature of the interactions. Both confidentiality and parental control are discussed as important considerations in developing the therapeutic alliance between therapist and parent. Two examples of this communication alliance are presented: the first example is a crisis situation, in which the student requires hospitalization. Treatment issues and management strategies are discussed, including the purpose of the first contact; when, and whom to contact; communication exchanges; and special concerns, e.g., decision making, second opinions, drugs, and diagnosis. The second example presented involves a noncrisis situation. Treatment issues and management strategies are discussed, including arranging for treatment, and parental involvement after treatment is in progress. (BL)

INITIAL COMMUNICATIONS WITH THE PARENTS OF EMOTIONALLY DISTURBED UNIVERSITY STUDENTS

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Abstract

Communicating with the parents of emotionally disturbed university students is a relatively infrequent but consistent and significant activity of students' therapists. Therapist, parent, and student attitudes about such communications are discussed. Examples are given of crisis and non-crisis situations leading to parent-therapist communications and suggestions are made for the management of each situation outlined. In all such encounters, the therapist's guiding objective is to forge with the parents an alliance designed to promote the growth and development of the student.

Communicating with the parents of emotionally disturbed university students is a relatively infrequent activity of students' therapists, but when such communication occurs, the relationship engendered between parents and therapist becomes critically important to the treatment of the student. My purpose is twofold: 1) to discuss some attitudes that may come into play and be influential when a parent enters the treatment picture with a disturbed student, and 2) to discuss some specific situations in which parents and therapist encounter one another and possible concerns and responses of both. The presentation of management alternatives will be omitted and the observations are made presupposing a setting in which parents are encountered usually without prior relationship with the therapist and usually due to circumstances of tension or crisis in which contact with them will be brief and at most sporadic. In any event, when encountering parents the therapist's guiding objective is to form an alliance designed to promote the growth and development of the student.

Literature Review

The literature is sparse. Blaine and McArthur[1] recount some of the issues that must be dealt with when contacting parents in emergency situations where hospitalization of a student is necessary. They advocate parental consultation and approval prior to hospitalization. This is not always practical. Trossman[2] delineated various situations in which a mental health service and parents came in contact. The majority of

students coming to his service lived at home. He described the students' problems with parents from a developmental frame of reference and differentiated conflicts which required no parental involvement with students' treatment from those which indicated a few sessions with parents or a recommendation for family treatment. The emphasis was on family dynamics rather than management problems per se, and the parental ambience was presumed to be pathogenic. There are scattered comments elsewhere relevant to parent participation in student treatment, usually made with reference to a case history.

General Considerations

1. Attitudes of Therapists Toward Parents

My impression is that the average expectable attitude of university student therapists toward parents would fall on a point somewhere on the line between: "Parents are a nuisance to be dealt with and dismissed as expeditiously as possible," and, "Parents, being the causal agents in the student's problem to begin with, are to be excluded at all costs from my corrective relationship with their child."

Where therapist anti-parental bias exists, it needs to be identified and at least controlled for, if not resolved. This is axiomatic if the therapist is to collaborate with parents successfully, but in a more subtle way it is just as true if therapy is to be optimum, even when there is no contact with the parents. Among the many reasons why therapist anti-parental bias is unuseful, one is a standout: blood is thicker than therapy. Any

therapist who vies seriously with parents for the loyalty of a student will, in all probability, find himself without a patient, regardless of whether this is done psychologically in the "therapy" per se, or in confrontation involving the parents directly. Parental control of students via purse strings is the reason most often cited by therapists and students. Psychological reasons are more pervasive and potent. On the average, students are far more identified with their parents than they are aware of, much less admit to. Where loyalty is not even particularly an issue, overtly or covertly derogating parents assaults the student in two ways: 1) some aspects of the characteristics being derided have usually been incorporated by the student, and 2) the possibility of genetic influence, including psychological characteristics, is nowadays much more in the public consciousness, students included.

A more moderate bias has developed perhaps as therapists have become aware of the concept of "the identified patient." Operating in this framework, it will be assumed that the student is the identified patient and the rest of the family are unidentified patients. This may be so, and often enough parents have identified themselves as patients elsewhere, but a student's therapist should not approach the parents as such directly as it is out of context and will only serve to distort communications and alienate parents. Regardless of what he has heard about the parents from the student, the therapist's proper approach is one that conveys the expectation that they will be a positive force in the collaborative effort to promote resolution of the emotional problem and forward progress in the student's development. In other words, the therapist keeps to himself his

speculations about or observations of potential parental pathological influences, and speaks only to the healthy side of their egos which he can assume is operating for the well-being of their child. Few parents are so enmeshed in their own problems that they cannot respond to this approach with at least an effort to exert a positive influence on their child's situation.

2. Attitudes of Parents Toward Emotionally Disturbed Students, Treatment, and Therapists

Assuming that parents have just been apprised that their child is in emotional difficulty, the announcement will "turn on" virtually simultaneously all of the following concerns, and more. This is the mental set that the therapist will be dealing with, but perhaps the questions from parents will come somewhat in the following order:

1) How serious is it?
2) What kind of difficulty?
3) Is he suicidal? (Few will think in terms of danger to others, and if this is the case, the shock will be tremendous.)
4) Need for hospitalization? If so, how long?
5) What are the immediate implications: Does this mean he will have to leave school: If so, will he ever return? Would school have him back? Can't he be treated and at least finish this semester?
6) Future implications: Does this mean chronic mental illness?
7) What do we need to do now: come down, have him come home, call often?

8) How do we relate to him now: What have we done wrong (clashes with child or lack of relationship, parental fighting, differences in child rearing practices, differences in other attitudes)?

And immediate background concerns, less often directly expressed:

9) Loss of control/influence over child's situation,

10) Adjustments and disruptions in parents' plans for semester or longer.

11) Expense: Of treatment; of dropping out of school if this is the case.

After being overwhelmed by a telephone introduction to a situation they only half believe exists, most parents will focus their attention on what is being done now. No list can be compiled of all the predictable fantasies a parent might have about treatment of emotional disturbances or about those who do it. Except in instances in which the child or some other family member has undergone sustained and successful treatment, the following general attitudes are predictable however: skepticism and misunderstanding of what the therapist is relating and a charge of negativity toward the bearer of bad news. This last reaction is primitive and "unacceptable" as such, but is ubiquitous and varies only in degree. Occasionally it is acknowledged. More often such personalized negativity toward an unknown party is bewildering to the parents and to the therapist if he isn't prepared for it. The foregoing parental concerns and attitudes represent a partial list only.

3. Attitude of Students Toward Parent-Therapist Communications

On the average, students probably have fewer concerns about seeing a therapist or their parents knowing of it than parents have about therapists and vice versa. Witness the number of students who tell their parents that they are being seen. But for some students, it signifies that they "couldn't make it on their own" or they think (or know) that their parents will see it as a stigma. Questions of loyalty also become involved. For the less independent, it is a question of what family secrets have been shared with the therapist and whether the family would see this as betrayal; for the more independent, it is a question of which personal matters shared with the therapist does the family need to know about. Most students' attitudes about parent-therapist interactions will be determined by the nature of the interactions, rather than by any preconceived ideas.

4. Confidentiality

Confidentiality exists to protect the interest of patients and penitents. It is not a divine right of therapists, but is a useful tool in treatment. The therapist must know the state law on privileged communications governing his discipline, and policies on same of organizations he represents. In the melange of gray areas uncovered by laws and policies, good common sense, good professional judgement, and maintaining the best interest of the patient will suffice except in precedent setting cases. A rigid approach to confidentiality will tend to obstruct therapist-parent communications and this is not good for alliances. For example, when a call from a parent starts with, "Have you talked with my son, X?", the

response should be in any case, "I can neither affirm nor deny this." Assuming the case in which the therapist has seen the student - and parents rarely ask that question when the therapist has not - a "Yes" response is an unnecessary breach of confidentiality and a "No" response will almost inevitably be followed by detail from the parent which makes it plain that only the student could have divulged the information. Being caught barefaced is an inferior way of commencing constructive dialogue. If the therapist's non-committal response doesn't bring on parental commentary, the former can follow up with a request for information and questions that may be pursued. The parent can give many particulars which can inform the therapist about both student and family, and the therapist can talk in generalities, including the need for proper authorization to communicate and the reasons therefore, in such a way as to lay the foundation for further communication. Parents are usually calling when the student is in crisis, in many cases of which the therapist would have been calling the parents in a matter of days, and in some of those cases without authorization.

5. Parental Control

Parental control is a major issue being continuously addressed covertly or overtly in the communications and negotiations between therapists and parents. It requires a full scale evaluation and many hours of therapy over time during which the control issue is made overt and its ramifications are reviewed in various contexts in order to deal with this one matter adequately. Such an undertaking requires the consent, cooperation, and

participation of the parties, in this case, parents. University students' therapists are rarely involved with parents in this manner, and in the brief and sporadic encounters that they usually do have, therapists' management of control issues is one of the major determinants in whether or not a productive alliance with the parents will occur. During initial encounters the therapist must not threaten or challenge the parents' sense of control over their child (from their standpoint the student has usually done more than enough of this already), but rather seek ways to reinforce their sense of control over their own feelings and behavior. Effecting this subtle shift of focus may be a difficult maneuver. Sometimes the therapist can promote the alliance by pointing out the limitations of his own role and armamentarium, and, while avoiding conveying a sense of anyone's powerlessness, suggest the importance of finding ways in which everyone can pull in the same direction.

Example Situations

Crisis. Announcing and Discussing Hospitalization.

Parents should be involved in the decision to hospitalize single students whenever this is possible. Often it is not, so we will assume that the student has been hospitalized and the therapist is his primary physician in the hospital. Some issues are similar if the parents are being brought into the decision to hospitalize or if the therapist has been involved in the hospitalization, turns the student over to a physician, and is speaking with the parents later.

1) Purpose of the first contact.

Therapists become accustomed quickly to severely out of control students. Parents usually are not and the impact on the latter of their child being hospitalized cannot be overestimated. The first call has the dual purpose of imparting information and assisting parents in keeping their anxiety within controllable limits. To the extent to which it can be achieved, the latter involves helping the parents focus on what they are going to do and this is accomplished by giving them what basic information is available from which to plan a course of action, including what is already being done. The best single measure of a future successful collaboration with parents is their ability to cope with uncertainty, as measured by relatively low levels of demand for more information and explanation than is possible in a new and evolving situation.

2) When and whom to contact.

It is preferable to have the student's cooperation before making the first contact. Many students "don't want their parents to know" and refuse to give permission, which is unrealistic except in the few cases where it is known that the student is totally out of contact with parents anyway. Twelve hours is about the practical limit of non-notification beyond which the probabilities begin to rise steeply that further delay will constitute an unproductive obstruction of the parents' need to do their parenting and hinder the formation of a constructive parent-therapist alliance. In the course of this time period, however, a number of students who initially refused to give permission will acquiesce. Some students wish to make the first call home themselves,

and this is usually appropriate for those who need that type of control. Such calls should be followed at once by one from the physician. It is preferable when both parents can be reached simultaneously, but the more usual course of events - which the therapist should foresee and plan for - is that one parent is reached during the day and the other or both will want contact in the evening. Occasionally a student will make a sharp distinction as to parent of choice to be contacted.

3) Initial exchanges.

The sequence is usually as follows: announcement of the hospitalization and immediate circumstances surrounding it; comprehension-seeking response by parent, more or less stunned; further elaboration of circumstances by therapist; ventilation of concerns by parent intermixed with responses to these by therapist; turn of focus to sequence of immediate actions parent will take.

After identifying himself fully, and then the parent, the therapist announces the hospitalization and its location and then quickly comments on the physical status of the student. a) In the event of physical harm or danger, such as after a suicide attempt, this fact must be disclosed along with the student's current condition and the measures being taken to improve it. At this juncture, details of how to get to the hospital (and the Intensive Care Unit if the student is being treated there) and what doctor to contact will be more important to the parents than background details as to what brought about the attempt. b) In the more usual case, after the therapist makes clear the absence of physical danger, he introduces

the rationale for hospitalization in general terms with such phrases as "sufficiently emotionally disturbed," and the "need to be where he can settle down while we are evaluating him further." By this time the parent is usually asking questions to which the therapist responds during which he asks about the parents' awareness of any upset in their child. If they have been aware, as is more usual, then the hospitalization can frequently be made more comprehensible to them by connecting what the therapist knows about the sequence of events with what they know. The student's current status and management are also more comprehensible when fitted into this framework.

If the parents have not been aware of any disturbance, then the therapist has the more difficult task of making comprehensible both the issue of emotional disturbance and the necessity for hospitalization. The situation is made even more difficult since the therapist is always trying to avoid transmitting embarrassing content not already known to the parents. Under these conditions the therapist can be concrete about and emphasize the overt symptoms and behaviors which led to the hospitalization and can properly defer an explanation of why the situation arose until later when more information is available. The intensity of the situation will lead to an increased tendency on the part of the therapist to try to reduce parental anxiety by giving more and more detail and explanation about the student's past and present state of mind. Such information usually just leads to more parental speculation, questions, and anxiety. Unless the student's life is in serious danger at this point or there is a threat of brain damage, a more reassuring therapeutic posture

is to suggest that the student himself will probably be able to throw more light on the situation in due course.

The therapist would like to be able to describe a situation serious enough to require hospitalization without being alarming. This is impossible, of course. To attempt to mitigate the alarm, the therapist tries to convey the perspective that the situation is serious but manageable and that its critical aspects are time-limited. If suicidal ideation is a major feature or the primary reason for the hospitalization, this must be addressed in the initial contact. Parents need time to process this information, it will come out sooner or later, and "shielding" them will only imply that they are not thought capable of dealing with it, an implication that will undermine their self-confidence. If suicidal ideation has occurred but is a secondary feature in the disturbance, mention of it can be deferred, unless the parent inquires directly. The therapist's hope is that the student will be able to incorporate this piece of content in context as he talks over his condition with his parents later.

4) Special Issues.

a) "Who made the decision to hospitalize?" The need for hospitalization is a medical judgement, of course, but the act is a decision in which the student does not participate if he is committed, does participate if he is not. In the former case the circumstances should be overwhelming enough to help convince the parents that the proper thing has been done. In the latter case, after outlining the reasons on which the medical judgement was based, it is important to introduce into the account the student's participation in the decision. This can include comments on

the student's good sense in seeking help, evaluating his own situation, and accepting medical opinion. This will help to alleviate parental anxiety that something has been done to their child or that he has lost his mind. It will usually help the credibility (in the eyes of the parents) of both the therapist and student if they are seen as having collaborated in the hospitalization. Parental anxiety is often further reduced when the reversible nature of the procedure is pointed out with the reassurance that the vast majority of such hospitalizations are relatively brief. At this point it can usually also be pointed out that when the parents have had time to talk with their child and acquire further information, they will most certainly be participating in the decision to discharge.

b) "We want a second opinion" - about either the need for hospitalization or the treatment. During initial communications, this represents, mostly, parental groping for control over the situation rather than an attack on the unknown physician (vide the ubiquitous negative reaction, however). The best response to this request or demand is an immediate agreement followed by an attempt to make some sort of personal connection between the parents and a local psychiatrist. Even a circuitous connection helps. For example, their family doctor is acquainted with a physician in the vicinity of the university and the latter recommends a psychiatrist. Suggesting the search usually enhances the therapist's standing with the parents; and if a physician is found with whom they feel some connection, their anxiety will be reduced.

c) "Was he using drugs?" Whether he has received general authorization from the student to speak with the parents or not, this is one question, the response to which the therapist will want to have discussed in advance with the student, if at all possible. The therapist is in the best position if the student gives him a "free hand," as a number of factors are at issue. Parents in general are properly aware that a substantial amount of experimentation with drugs (alcohol included) takes place on campuses, and they are more aware than are their children of the general level of association between drug use and emotional and behavioral disorders, so the question is a natural one. If it can be answered with a flat "No," a great deal of inappropriately based anxiety can be got out of the way (although they may later on wish the hospitalization had resulted from a state of temporary intoxication). If the answer is "Yes," meaning acute toxicity, the usually brief nature of the immediate state can be pointed out. Chronic drug abuse will always be a factor in management and planning for the student, even if it is not the primary cause of hospitalization, so it might as well be addressed and put into context when the question is asked. When drug use or abuse has occurred, parents almost always find out about it, usually from their child and soon. Better that they should receive accurate information in a balanced discussion from the therapist, for if the latter withholds, the damage is immense to his credibility and that of future therapists. If the student tells the therapist not to duscuss drug use, the best that the therapist can do is to refer the parents to the student for comment. Even under the stress of their child's being hospitalized, most parents are able, without excessive anxiety, to

defer discussion of many content areas other than drugs until they can talk with their child directly.

d) "What is the diagnosis?" At the time of initial communications, the diagnosis has often not been firmly fixed, but in any event the therapist must first find out what the parents mean by the question. If the question is fundamental and means "Do you have a guidepost to treatment?", the response can almost always be affirmative, even if it is most preliminary, and it can be dealt with in symptomatic rather than diagnostic terms. If the parents mean a final diagnosis in technical terms with prognostic import, the therapist will not be able to give this at this juncture, but he needs to pursue the implications of the question in terms of the anxieties it represents, which may be based on a great deal of relevant observation of the student, family history, or even prior evaluation.

Non-Crisis.

Contacts are less frequent with parents of students who are not in medical and/or academic crisis. They occur under conditions of less stress for all and so tend to be less problematic, but not necessarily so.

1. Arranging for treatment.

Occasionally a parent will contact the therapist and/or bring the student to get the latter established in treatment, often as follow up to treatment in or out of a hospital. This can be a good occasion for the therapist to establish a relationship with the parents as well as getting a history from them during which their relationship with their child can be explored. Also, the therapist can find out about their

expectations of treatment and try to rectify misconceptions they may have about what treatment can do and/or what the therapist expects to be doing in treatment. Comments such as "we only want the best" and "we have heard such good things about you" call for a particularly vigorous discussion of parental expectations about treatment. Parental expectations as to future communications should be established and it is well to have from the student full authorization for communications in advance in a situation that has a higher than average probability of proceeding to crisis. Finally, financial responsibility and limitations can be established. When parents are making arrangements for a student's treatment, they often have definite opinions about which discipline they want. The student's feelings should be sought, of course, but if there is no manifest conflict, the parent's wishes should be acceded to without further comment, and an offer made to help them find a therapist of their preferred persuasion if they are not already talking to one. The aim is to promote the parents' support of treatment and this is not best done at this point by challenging their choice or educating them as to differences among the disciplines. If a preferred discipline is simply inaccessible, all one can do is review the available resources. If the parents ask the therapist's opinion about what discipline or therapeutic persuasion would be appropriate to the situation, then the therapist is invited into the role of educator and should speak freely, while acknowledging his bias and his preliminary and limited knowledge of the student's clinical status. The therapist can offer a brief description of his treatment armamentarium and a modest opinion of his judgement as to when and when not to use his various tools.

If, after discussion, the parents or the student seem to be uneasy about the therapist's approach, the therapist can best serve by participating in the search for a closer match with parental or student wishes.

Once they have settled upon a given therapist to treat their child, parents will sometimes say, "We are putting you in charge." This is often said by parents who live far away or whose own activities make them literally unavailable for periods of time, but the therapist needs to check out in some detail just what he is being put in charge of. The aim is to limit his charge to therapy and to eliminate other responsibilities, but even this can be deceptive, because there is no way to define precisely the role of the therapist. What the therapist needs to achieve, most basically, is the position in which it is agreed that it will be left to his judgement as to what to communicate to the parents and when to communicate it. The therapist should understand that they don't mean "everything," and provide them with some ready examples that will at least give them pause for reflection, such as hospitalization. This is the decision in which the therapist will be most influential. Do the parents want to know absolutely in advance of the fact? What about an emergency? Then the therapist must give them some of his criteria for an emergency. What about dropping out of school or a medical leave of absence? When do they want to be brought into this - as soon as it is brought up in therapy, before any final decision is made, afterwards? What about changes in career direction or major? When do they want to be brought into these decisions? What about major life incidents, not necessarily affecting administrative status, such as being raped or shot at? When do they want to know about such, if ever?

The responses to these situations will not provide for all contingencies, but they should help to give everyone a better understanding of how much the parents are willing to rely on the judgement of the child, how much on the therapist, and at what point they are going to want to be brought in on any decision making. The responses will give a baseline to which the therapist can refer in deciding when he is expected to communicate with the parents. There are times when it may be useful to get a signed agreement in writing.

2. Entering a treatment in progress.

Once a student has been in treatment with a therapist, parental attempts to involve themselves in the treatment are usually much more problematic for both student and therapist. However a contact initiated by a parent at that point may be to let the therapist know that the parents are supportive of treatment, to provide information, to ask the therapist if he wants information, or to let the therapist know of their availability if needed.

If the parents want information about the student or about the treatment, the situation becomes more problematic and the first step is to secure from the student an authorization for communication. At this time, the therapist can learn from the student the latter's view of why the parents are becoming involved at this time and how the student feels about it.

Assuming that authorization is granted, the therapist can then take up with the parents their questions about their child's condition.

the need for treatment, what treatment is being given, and other issues of their concern (see General Considerations).

If the therapist is contacted directly by the parents or if the desire for such contact is communicated through the student and the student does not grant authorization (and the therapist should give the reasons for this denial a very thorough review) the therapist should send the parents a letter stating simply that he has no authorization to communicate with them. He will do well to include in the letter an expression of his desire in general to communicate with parents but explaining that there are times in students' lives, usually of relatively short duration, when they want to exclude parents from their problem solving efforts.

Conclusion

In order to collaborate with parents properly the need for a great amount of time should be clear by now. If the mental set of the therapist is that parents are at best a distraction, little time will be given them and that, grudgingly. The tension thus generated will undermine treatment of the student.

Whether the encounter with parents is unscheduled due to crisis, as in the majority, or scheduled at the convenience of the therapist, the latter needs to make time available. Experience will show that it takes more time than therapists expect, for example, thirty minutes for a "5 minute" phone call, three hours for a one hour office session. (These requirements become reduced, of course, with repeated contacts over an

extended period with the same parents.) A "plenty of time" approach relieves both therapist and parents of much pressure immediately and allows them to arrive in relatively orderly fashion at the conclusion that not all the problems at issue can be resolved at once but that they have had a thorough review, that plans are in place, and that therapist and parents have established some common vocabulary for use in future communications.

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Table 3 Change Variables: Increment in Explained Variance (R^2) of Needs at Time 2[a]

	Poor Health (PH) N=43	Good Health (GH) N=90	High Stress (HS) N=33	Low Stress (LS) N=100
Needs (Time 1)	.17[c]	.01	.22[c]	.01
Interactional Data Set (Time 2 minus Time 1)	.08	.20[c]	.21	.15[c]
Structural Data Set (Time 2 minus Time 1)	.11	.03	.10	.02
Total Variance Explained by Network Change Set	.19	.23[b]	.31	.17[b]

(a) Hierarchical regression analysis
(b) $P < .05$
(c) $P < .01$